DEVELOPMENT AND APPLICATION OF AN INDEX OF DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT

The DDCAT

methodology and measure:

Background and overview

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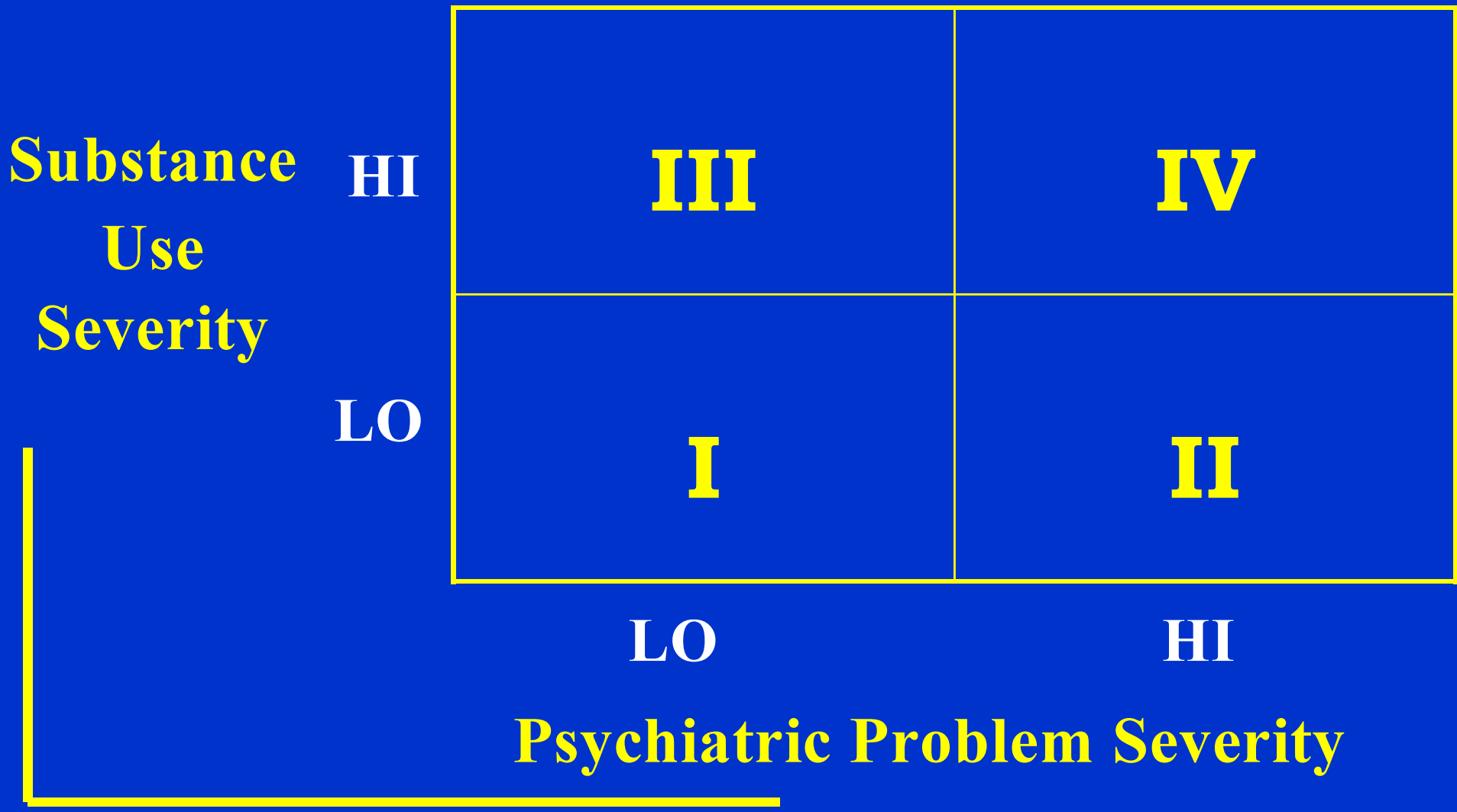
QUADRANT MODEL FOR CO-OCCURRING DISORDERS



GENERAL EVIDENCE FOR EFFECTIVE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS

- Studies of psychiatric severity, generic psychological treatment, and duration of services associated with therapeutic benefits (McLellan et al, 1983: Moos et al, 2001)(Q3)
- Integrated Dual Disorder Treatment (Drake et al, 1993; Mueser et al, 2003)(Q2)
- Randomized controlled trials (RCTs) with specific comorbidites (Watts et al, 2004)(Q3)

STATEMENT OF THE PROBLEM

- **Practices for co-occurring disorders are both consensus and evidence-based (CSAT TIP#42).**
- **A good deal of progress has been made in mental health settings for persons with severe and persistent mental illnesses, however, this is not the largest segment of persons with co-occurring disorders.**
- **Clinicians, programs, agencies and systems are motivated, *internally and externally,* to improve services for persons with co-occurring psychiatric disorders in addiction treatment programs, and seek specific and objective approaches.**

SPECIFIC AIMS

A. To objectively determine the dual diagnosis capability of addiction treatment services.

B. To develop practical operational benchmarks or guidelines for enhancing dual diagnosis capability.

TWO EXISTING MEASURES OF DUAL DIAGNOSIS CAPABILITY

1. The Comorbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS)

- **Adult & Adolescent Program Audit Tool for Dual Diagnosis Capability**
- **Ken Minkoff & Christine Cline (2002)**
- **Designed for either mental health or addiction programs**
- ***Leans* in the direction of mental health program & SMI clients in utility (Q2)**

TWO EXISTING MEASURES OF DUAL DIAGNOSIS CAPABILITY (cont.)

2. Integrated Dual Disorder Treatment Fidelity Scale

- IDDT developed and standardized in MH settings.
- IDDT model for persons with SMI (Q2)
- Does not appear to fit in addiction treatment settings according to providers (or IDDT developers)
- Mueser, Drake et al (2003)

SOME DIFFERENCES BETWEEN MENTAL HEALTH AND ADDICTION TREATMENT SYSTEMS AND SERVICES

1) Historic and cultural
2) Levels of care (physical settings)
3) Workforce
4) Evidence-based practices
5) Role of assertive community treatment
6) Persons served

(MH: Q1, Q2 & Q4; ATS: Q1, Q3 & Q4)

THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S TAXONOMY (ASAM-PPC-2R, 2001)

- ADDICTION ONLY SERVICES (AOS)
- DUAL DIAGNOSIS CAPABLE (DDC)
- DUAL DIAGNOSIS ENHANCED (DDE)

ADDICTION ONLY SERVICES (AOS)

Programs that either by choice or for lack of resources, cannot accommodate clients who have psychiatric illnesses that require ongoing treatment, however stable the illness and however well-functioning the client.

DUAL DIAGNOSIS CAPABLE (DDC)

Programs that have a primary focus on the treatment of substance-related disorders, but are also capable of treating clients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health problems related to an emotional, behavioral or cognitive disorder.

DUAL DIAGNOSIS ENHANCED (DDE)

Programs that are designed to treat clients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders.

THE NEED FOR A RELEVANT DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) MEASURE

- ASAM offers the road map, but no operational definitions for services
- Fidelity: Adherence to an evidence-based practice or model
- Fidelity scales: Objective ratings of adherence (e.g. IDDT Fidelity Scale)
- Need for objective ratings of adherence to consensus clinical guidelines or principles: Index

USING THE FIDELITY SCALE METHODOLOGY FOR OBJECTIVE RATINGS OF DUAL DIAGNOSIS CAPABILITY

- Site visit (yields data beyond self-report)
- Multiple sources: Chart, brochure & program manual review; Observation of clinical process, team meeting, & supervision session; Interview with agency director, clinicians & clients.
- Objective ratings on operational definitions using a 5-point scale (ordinal)

ENHANCING DUAL DIAGNOSIS CAPABILITY IN A SINGLE STATE'S ADDICTION TREATMENT SYSTEM

- STAGE I STUDY

  Baseline needs assessment and objective study of actual co-occurring disorder treatment –

  Survey of 456 providers

- STAGE II PHASE I STUDY

  Developing an index to more objectively assess programs' dual diagnosis capability –

  Instrument construction & field testing for feasibility

STAGE I: ADDICTION TREATMENT PROVIDER SURVEY (n=456): SELF-REPORTED PROGRAM TYPE BY ASAM-PPC-2R DUAL DIAGNOSIS CAPABILITY TAXONOMY

Addiction – Only	54 (12.8%)
Dual Diagnosis – Capable	238 (60.2%)
Dual Diagnosis – Enhanced	113 (26.9%)

STAGE I FINDINGS: ASAM DUAL-DIAGNOSIS PROGRAM TYPE IS SIGNIFICANTLY CORRELATED WITH REPORTED PRACTICES

- Prevalence estimates
- Screening and assessment practices
- Treatment practices
- Attitudes
- Training needs
- Barriers and resources
- Workforce characteristics (profession, experience)

STAGE II PHASE I: DDCAT FEASIBILITY STUDIES

- Index (instrument) construction
- Feedback from experts in dual-diagnosis treatment and research, state agency administrators, addiction treatment providers, and fidelity measure innovators
- Field testing the DDCAT index 1.0
- Site visits and self-assessments
- Key questions:

  1) Is it doable?

  2) Does it provide useful information and for whom?

  3) How does the index hold up?

STAGE II PHASE I: DUAL-DIAGNOSIS PROGRAM TYPE SUMMARY(n=14 agencies; CT & MO)

ASAM Category	Total	%
AOS	4	29
AOS/DDC	6	43
DDC	1	7
DDC/DDE	3	21
DDE	0	0

DDCAT PSYCHOMETIC PROPERTIES

SUMMARY OF FINDINGS

- Median alpha = .81 (Range .73 to .93)
- Inter-rater reliability: % agreement = 76%
- Kappa = .67 (median)
- Relationship to IDDT fidelity scale: r = .69 ($p < .01$) (DDCAT scale score r range: Assessment =.33 to Treatment =.82)

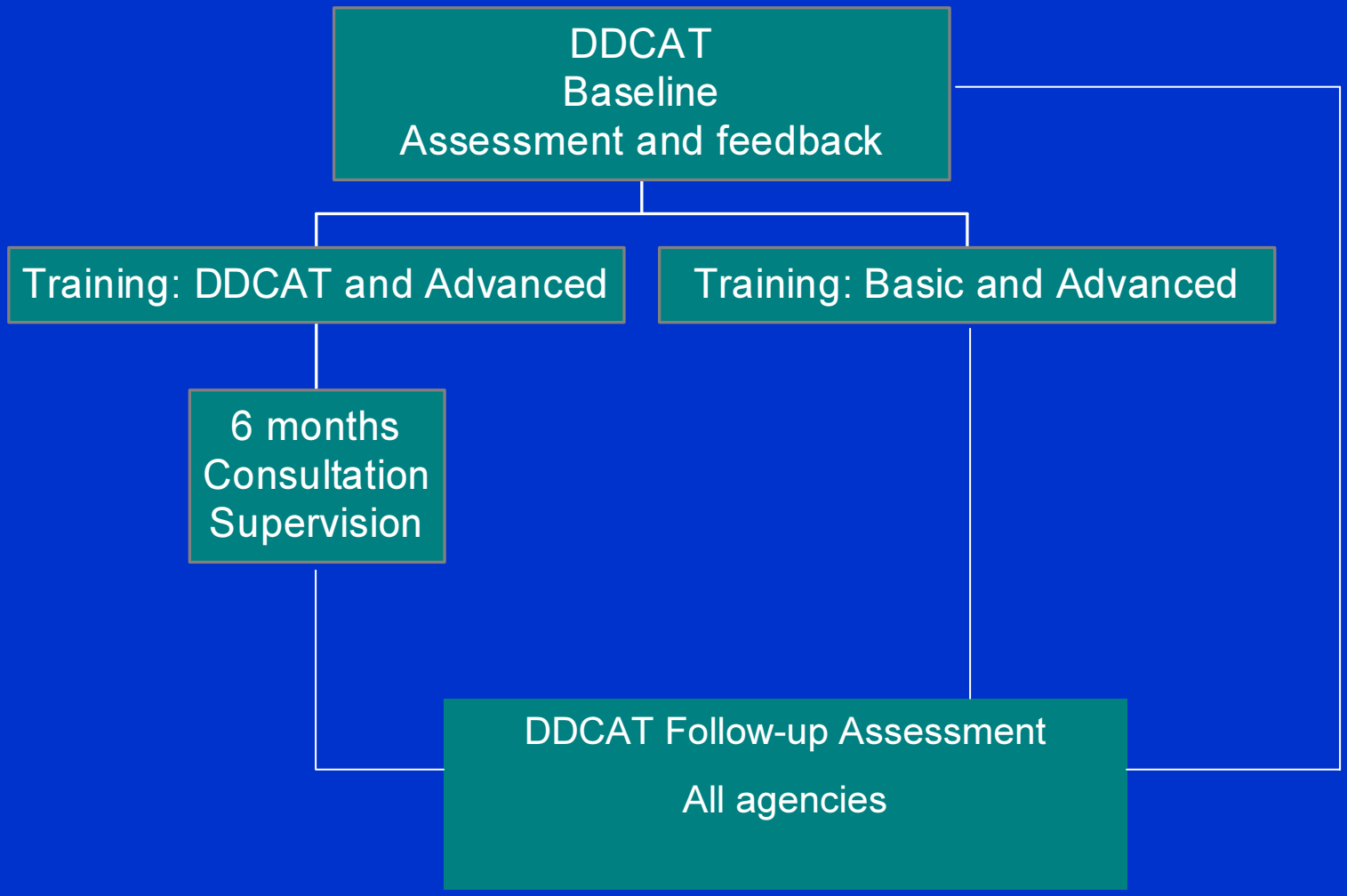
STAGE II PHASE I: SUMMARY OF FINDINGS

- 20 programs in NH: Self-assessment
- 7 programs in CT & 7 in MO: Site surveys
- Demonstrated feasibility in:
  - DDCAT ratings feasible using both formats
  - Useful process for providers and state agency:
    User-friendly, concrete, self-assessment, identifies specific avenues for change
- Acceptable psychometric properties

STAGE II PHASE II:
DDCAT PROJECTS NOW IN PROGRESS

1. Continuing refinement of instrument and establishing psychometric properties (reliability &validity) (Version 2.3)
2. Implementing targeted training and systems change procedures to advance dual-diagnosis capability (e.g. Basic, Advanced).
3. Testing models of enhancing dual-diagnosis capability: Assessment only, assessment plus training, or assessment plus training and ongoing supervision.

STAGE II PHASE II: PROJECT DESIGN



STAGE III PROPOSALS

1. Broader use of DDCAT (benchmarks, cost data)
2. Agencies' ongoing use DDCAT for self-assessment, planning of services, strategic staff training and as measure of change.
3. State leadership: Map the capability of the system, measure change, rational service system design, standards & resource allocation.
4. Link DDCAT with other sources of data (e.g. MIS, actual treatments received, client outcomes).
5. RWJ SAPRP grant application resubmission (#s 2 – 4): CT, ME, MO, OR, NH & VT (others welcome).

THE DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT INDEX:

DDCAT *Version 2.3*

DDCAT INDEX DIMENSIONS

I. PROGRAM MILIEU
II. CLINICAL PROCESS: ASSESSMENT
III. CLINICAL PROCESS: TREATMENT
IV. CONTINUITY OF CARE
V. PROGRAM STRUCTURE
VI. STAFFING
VII. TRAINING

DDCAT INDEX RATINGS

1 - Addiction only (AOS)

2 -

3 - Dual Diagnosis Capable (DDC)

4 -

5 - Dual Diagnosis Enhanced (DDE)

PROGRAM STRUCTURE

I.A. Primary treatment focus as stated in mission statement

Is the stated focus addiction only, primarily addiction (with an acknowledgement of psychiatric problems) or dual diagnosis?

PROGRAM STRUCTURE

I.B. Organizational certification and licensure

What does licensure/certification permit?

Are there impediments to providing certain types of services?

Are these impediments real?

PROGRAM STRUCTURE

I.C. Coordination and collaboration with mental health services.

How & where are psychiatric services provided?
Through relationships or integrated?

Are these relationships formalized & documented?

PROGRAM STRUCTURE

I.D. Financial incentives.

How do billing structures limit or incentivize services for persons with addiction and/or psychiatric disorders?

PROGRAM MILIEU

II.A. Routine expectation of and welcome to treatment for both disorders.

What clients are expected and welcomed?
How is this reflected in agency documents?

PROGRAM MILIEU

II.B. Display and distribution of literature and patient educational materials.

What kind of information is posted on walls, on display in waiting areas, and included in patient & family handouts and printed materials?

CLINICAL PROCESS: ASSESSMENT

III.A. Routine screening methods for psychiatric symptoms

Are there routines or systems to screen for psychiatric problems?

Are screening instruments used?

CLINICAL PROCESS: ASSESSMENT

III.B. Routine assessment if screened positive for psychiatric symptoms

If a client screens positive, are more detailed assessments triggered?

Are these assessments formalized & integrated?

CLINICAL PROCESS: ASSESSMENT

III.C. Psychiatric and substance use diagnoses made and documented

If assessments are conducted, are psychiatric diagnoses made in addition to the substance use disorder?

CLINICAL PROCESS: ASSESSMENT

III.D. Psychiatric and substance use history reflected in medical record.

Are the chronologies and treatment course of disorders gathered (and recorded)?

CLINICAL PROCESS: ASSESSMENT

III.E. Service matching based on psychiatric symptom acuity

What happens to clients who present for treatment with stable psychiatric symptoms,

or unstable ones?

CLINICAL PROCESS: ASSESSMENT

III.F. Service matching based on severity of persistence and disability

What happens to clients who present with histories or reports of severe and/or persistent psychiatric problems?

CLINICAL PROCESS: ASSESSMENT

III.G. Stage-wise treatment – initial

Is stage of motivation assessed and documented?

Does it influence what treatment a client gets or how s/he is approached?

CLINICAL PROCESS: TREATMENT

IV.A. Treatment plans

Do treatment plans show an equivalent and integrated focus on both substance use and psychiatric disorders, or do they primarily focus on substance use issues only?

CLINICAL PROCESS: TREATMENT

IV.B. Assess and monitor interactive courses of both disorders.

Are changes and/or progress with status and symptoms of both psychiatric and substance use disorders followed (and noted)?

CLINICAL PROCESS: TREATMENT

IV.C. Procedures for psychiatric emergencies and crisis management

Are there definite protocols for psychiatric crises and/or those at high-risk?

CLINICAL PROCESS: TREATMENT

IV.D. Stage-wise treatment – ongoing

Is stage of motivation assessed on an ongoing basis?

Can treatment be revised based upon changes in motivation?

CLINICAL PROCESS: TREATMENT

IV.E. Policies and procedures for medication evaluation, management, monitoring and compliance

Are medications acceptable?

Are certain medications unacceptable?

Are medications routine & integrated?

CLINICAL PROCESS: TREATMENT

IV.F. Specialized interventions with MH content

Are therapies available that focus on addiction only, generic psychological concerns, or focused on specific psychiatric disorders (in addition to substance use treatments)?

CLINICAL PROCESS: TREATMENT

IV.G. Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment

Is information available on how substance use impacts a psychiatric disorder and vice versa?

CLINICAL PROCESS: TREATMENT

IV.H. Family education and support

Are family members provided information on how substance use impacts a psychiatric disorder and vice versa?

What kind of support is available for families on these issues?

CLINICAL PROCESS: TREATMENT

IV.I. Contingency management promoting treatment adherence for both disorders

Are contingency management techniques (positive, negative) used to promote abstinence, treatment compliance, or medication compliance?

CLINICAL PROCESS: TREATMENT

IV.J. Specialized interventions to facilitate use of self-help groups

In facilitating the connection to self-help groups, how are psychiatric disorders considered? Are specialized introductions available?

CLINICAL PROCESS: TREATMENT

IV.K. Peer recovery supports for patient with CODs

Are peer supports and role models available for clients with co-occurring substance use and psychiatric disorders?

If so, are they on or off site, integrated with programming?

CONTINUITY OF CARE

V.A. Co-occurring disorder addressed in discharge planning process

Is recovery from both psychiatric and substance use disorders considered when developing a discharge plan?

CONTINUITY OF CARE

V.B. Capacity to maintain treatment continuity

How is treatment terminated or continued?

Is this equivalent for both addiction and psychiatric disorders?

CONTINUITY OF CARE

V.C. Focus on ongoing recovery issues for both disorders

Are the disorders seen as acute or chronic, short-term or long-term, primary or secondary?

How is recovery envisioned and planned?

CONTINUITY OF CARE

V.D. Facilitation of self-help support groups for COD is documented

Is the potential increased self-help linkage difficulty for the person with a psychiatric disorder anticipated and planned for?

How is it dealt with?

CONTINUITY OF CARE

V.E. Sufficient supply and compliance plan for medications is documented

How is the need for continued prescribing and supply dealt with?

STAFFING

VI.A. Psychiatrist or other physician

What is the relationship with a psychiatrist, physician, or nurse practitioner (or other licensed prescribers)?

STAFFING

VI.B. On site staff with mental health licensure

Are any staff licensed to provide mental health services?

STAFFING

VI.C. Access to mental health supervision or consultation

What is the arrangement for mental health supervision and/or consultation for non-licensed staff?

STAFFING

VI.D. Supervision, case management or utilization review procedures emphasize and support COD treatment

Is there a protocol to review the progress or process of treatments for psychiatric disorders?

STAFFING

VI.E. Peer/Alumni supports are available with co-occurring disorders

Are role models available for persons with co-occurring addiction and psychiatric disorders?

TRAINING

VII.A. Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric disorders

Who has basic training in screening & assessment?

Is training documented?

TRAINING

VII.B. Staff are cross-trained in mental health and substance use disorders,

Including pharmacotherapies & specialized psychosocial treatments

Who is trained?

Is staff training guided and monitored?

DDCAT INDEX: SCORING AND INTERPRETATION

- 7 dimension scores: Average (Sum of ratings divided by number of items)
- Overall DDCAT score: Sum of dimension scores divided by 7)
- Categorization of program by Overall DDCAT score: AOS, AOS/DDC, DDC, DDC/DDE, DDE
- Categorization of program by category based upon % of criteria met: Cutoff = 80% or greater
- Qualitative interpretation and feedback

DDCAT INDEX: ADMINISTRATION & FEEDBACK

- Parallel process to clinical interaction: Respect and tone
- Assessing organizational stage of readiness
- Affirmation of strengths; Elicit concerns and/or areas of potential growth and perceived barriers
- Discuss potential strategies for enhancement
- Incentives and monitoring

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